Instructions – Open Enrollment Change Request Form for Retirees

The Open Enrollment period allows you the opportunity to change your health plan, eligible dependents, or enroll in a health plan. Any health plan changes during Open Enrollment become effective the following January 1. To make an Open Enrollment change, complete the request form (HBD-30), and mail it to CalPERS. If you prefer, you can call CalPERS and make changes over the phone. All changes are subject to verification of eligibility. Call CalPERS for eligibility information.

Mail the HBD-30 and all other requests to:	**For further information, please contact:**
Office of Employer & Member Health Services P.O. Box 942714 Sacramento, CA 94229-2714	Toll Free: **888 CalPERS** (or **888**-225-7377) TTY: 800-735-2929 FAX: 916-795-1277

INSTRUCTIONS FOR COMPLETING HBD-30	
TYPE OF CHANGE	Check the type of change(s) you are making.
RETIREE INFORMATION	Complete all retiree information. Be sure to include the name of the agency from which you retired.
HEALTH PLAN	Before requesting a plan change, verify that the doctor you want is contracted with the health plan and accepting new patients. If not, you will need to find another doctor who contracts with the new plan.
DEPENDENT INFORMATION	List only the dependents you are adding. All dependents currently enrolled on your health plan will remain on your plan. Adding a spouse requires a copy of your ***Marriage License.*** Adding a domestic partner requires a registered ***Declaration of Domestic Partnership*** form. **Important:** If the dependent(s) you are adding is eligible for Medicare Parts A and B, a **copy** of the Medicare card or ***Notice of Entitlement*** letter must be returned with this form.
RETIREE'S SIGNATURE	The signature of the retired member is required.

NOTE

- Be sure to report changes to CalPERS in a timely manner to avoid retroactive reimbursement liability.
- After changing your health plan, be sure to examine your retirement check to verify that the proper deduction is made. If the deduction is incorrect, call CalPERS to report the discrepancy.
- If you are enrolled in a Medicare Managed Care plan (Medicare Advantage) and are switching to a Supplement to Medicare plan, you must contact your current health plan or the nearest Social Security Administration office to disenroll your Medicare benefits from your current Medicare Managed Care plan (Medicare Advantage). If you do not disenroll, Medicare will not pay your new health plan for services.

Do not use this form to cancel your health coverage or delete a dependent. Make your request by calling or writing CalPERS. Include your Social Security number, daytime phone number, mailing address, the type of change, and the reason for change. The effective date for change, other than Open Enrollment changes, depends on the reason for the requested change and date received. For more information on effective dates, call CalPERS at **888 CalPERS** (or **888**-225-7377)

CalPERS
Office of Employer & Member Health Services
P.O. Box 942714
Sacramento, CA 94229-2714
888 CalPERS (or **888**-225-7377)/TTY 800-735-2929

Changing Plans? Open Enrollment plan changes can be done over the phone by calling **888 CalPERS** (or **888**-225-7377)

Date Called:_____

Name of Representative:_____

To save time, complete this form before you call to request changes over the phone.

Open Enrollment Change Request Form For Retirees

(For Retirees only. Active employees - contact your Personnel Office.)

Changes effective the following January 1.

TYPE OF CHANGE

❒ **Change My Health Plan.** (Complete ***Retiree Information***, ***Health Plan***, and ***Retiree Signature***.)

❒ **Add Eligible Dependents to My Health Plan.*** (Complete ***Retiree Information***, ***Dependent Information***, and ***Retiree Signature***.)

❒ **Enroll in a Health Plan.**** (Complete all sections.)

RETIREE INFORMATION

Social Security Number – –	Last Name	First Name	MI	Retirement Date (MM/YY)
Date of Birth (MM/DD/YYYY)	Home Address		Mailing Address (if different)	Apt/Unit #
Daytime Phone Number ( )	City	State	ZIP	County (residence)

Male ❒ Female ❒

Name of agency or school district retired from:

Are you or any of your dependents on Medicare disability?
Member ❒ Yes ❒ No
Dependent ❒ Yes ❒ No
If yes, send a copy of Medicare cards.

Are you or any of your dependents enrolled in both Parts A & B of Medicare?*
Member ❒ Yes ❒ No
Dependent ❒ Yes ❒ No
If yes, send a copy of Medicare cards.

HEALTH PLAN

Name of New Health Plan	Name of Doctor/Medical Group (include ID#s, if known)

DEPENDENT INFORMATION

Dependents to be Added	Social Security Number	Date of Birth (MM/DD/YYYY)	Relationship	Doctor or Medical Group
	– –			
	– –			
	– –			
	– –			

RETIREE'S SIGNATURE

By signing this form, I elect to change to the plan indicated above and/or add eligible family members. I also certify that the health information listed above is true and complete and authorize deductions, if applicable, to be made from my retirement allowance to cover my share of the cost of enrollment.

Signature of Retiree _____ **Date Form Signed**

* Adding a spouse requires a copy of your marriage license. Adding a domestic partner requires a registered Declaration of Domestic Partnership. Adding an economically-dependent child requires an Affidavit of Eligibility. Contact your former employer or CalPERS for more information concerning eligibility requirements.

** You can enroll in the CalPERS Health Program if you:
- Retired from the State of California, a school district, or a public agency that contracts with CalPERS to provide health benefits for its retirees,
- Are receiving a retirement check, and
- Retired within 120 days from the day you separated from your job.